MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Active Behavioral Health, L.L.C. 6300 Samuell Blvd., Suite, 112 Denton, Texas 75228	MDR Tracking No.: M4-04-4130-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Ploy America, Inc. Box 01	Date of Injury: Employer's Name: Insurance Carrier's No.: PA010010

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement states, "This is the initial intake for Active Behavioral. No pre-auth is required, as this service was referred by the treating doctor."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a position statement. Carrier's EOB denial is "V-Unnecessary treatment with peer review."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per rule 133.301(a), Carrier shall not retrospectively review the medical necessity of a medical bill for which the requestor obtained preauthorization.

Therefore, based on the information that the requestor obtained preauthorization, reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

4/2/2003	90900	$120.00	$120.00				
4/2/2003	90904	$120.00	$120.00				
4/2/2003	90906	$120.00	$120.00				
4/2/2003	90915	$120.00	$120.00				
4/9/2003	90844	$120.00	$120.00				
4/9/2003	90889	$30.00	$30.00				
4/30/2003	90844	$120.00	$120.00				
4/30/2003	90889	$30.00	$30.00				
				Total Left Column:			$930.00
				Total Amount Due:			$930.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$930.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	01/03/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____